

NOR CAL VAPE

REDDING, CA (SHASTA COUNTY)

- 4100 customers who could turn back to smoking or seek black market vapor products
- 7 employees that will be laid off (two vets, one single mom, three employees who had not worked for over a year before becoming employed in the vapor industry)
- Husband and wife run small business will be forced to close their doors-NOT ONE SINGLE ITEM WE SELL WAS MADE BEFORE 2007
- \$65,000 annual sales tax forfeited
- \$100,000 annual wages paid-GONE
- Downtown property would become vacant again
- 3 year lease that will be defaulted on

THERE ARE APPROXIMATELY 1500 VAPE SHOPS IN CALIFORNIA

- Millions of Californians could turn back to smoking or seek black market vapor products
- 15,000 vape shop employees laid off (=unemployment)
- 1500 small businesses will be forced to close
- \$97.5 million in annual sales tax forfeited
- \$150 million in annual wages paid-GONE
- 1500 commercial properties will be vacant

THESE NUMBERS DO NOT INCLUDE AN ADDITIONAL 500 DISTRIBUTORS AND MANUFACTURERS IN CALIFORNIA

- 5000 additional jobs lost (=unemployment)
- \$10 million in additional lost wages
- 500 additional vacant commercial properties

9 million people in the united states depend on vaping. If these regulations go through as written, one of two things will happen:

- People will go back to deadly combustible cigarettes-A 2011 study of 3587 participants showed that **79% believe they would go back to smoking** if they stopped using e-cigarettes (which would happen if these regulations pass as written). * study attached
- People will seek unsafe, unregulated black market products that could lead to substantial health hazards.

According to the American Cancer Society, **smoking related illness cost the US \$133 BILLION** in 2013. * report attached

According to Tobacco Free CA, **smoking related illness cost CA \$9.6 BILLION** in 2004. * report attached

According to State Budget Solutions, **E-Cigarettes Poised to Save Medicaid Billions**. * Report attached

Solution: recommend the grandfather date be changed to the date that the deeming regulations are finalized.

This will save tens of thousands of small businesses, reduce health care costs associated with smoking related illness and death, and potentially save the lives of millions of vapers.



Electronic cigarette: users profile, utilization, satisfaction and perceived efficacy

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2. Chris Bullen²

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Issue



Addiction

Volume 106, Issue 11, (doi/10.1111/add.2011.106.issue-11/issuetoc) pages 2017–2028, November 2011



²⁹ (http://www.altmetric.com/details.php?domain=onlinelibrary.wiley.com&citation_id=204897)

Additional Information

How to Cite

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Keywords:

E-cigarette; electronic cigarette; electronic nicotine delivery systems (ENDS); internet; nicotine; smoking; tobacco

ABSTRACT

79% OF EX-SMOKERS (WHO VAPE)
FEAR THEY MIGHT RELAPSE TO SMOKING

Aims To assess the profile, utilization patterns, satisfaction and perceived effects among users of electronic cigarettes ('e-cigarettes').

Design and Setting Internet survey in English and French in 2010.

Measurements Online questionnaire.

Participants Visitors of websites and online discussion forums dedicated to e-cigarettes and to smoking cessation.

Findings There were 3587 participants (70% former tobacco smokers, 61% men, mean age 41 years). The median duration of electronic cigarette use was 3 months, users drew 120 puffs/day and used five refills/day. Almost all (97%) used e-cigarettes containing nicotine. Daily users spent \$33 per month on these products. Most (96%) said the e-cigarette helped them to quit smoking or reduce their smoking (92%). Reasons for using the e-cigarette included the perception that it was less toxic than tobacco (84%), to deal with craving for tobacco (79%) and withdrawal symptoms (67%), to quit smoking or avoid relapsing (77%), because it was cheaper than smoking (57%) and to deal with situations where smoking was prohibited (39%). **Most ex-smokers (79%) feared they might relapse to smoking if they stopped using the e-cigarette.** Users of nicotine-containing e-cigarettes reported better relief of withdrawal and a greater effect on smoking cessation than those using non-nicotine e-cigarettes.

Conclusions E-cigarettes were used much as people would use nicotine replacement medications: by former smokers to avoid relapse or as an aid to cut down or quit smoking. Further research should evaluate the safety and efficacy of e-cigarettes for administration of nicotine and other substances, and for quitting and relapse prevention.

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Tobacco: The True Cost of Smoking

Tobacco use remains the single largest preventable cause of disease and premature death in the US, yet more than 45 million Americans still smoke cigarettes. As of 2013, there were also 12.4 million cigar smokers in the US, 8.8 smokeless tobacco users and 2.3 million who smoke tobacco in pipes.

This infographic illustrates findings from the Tobacco Atlas, 5th Edition, that show the significant harm, both financial and physical, that tobacco use causes to the smoker and to society at large.

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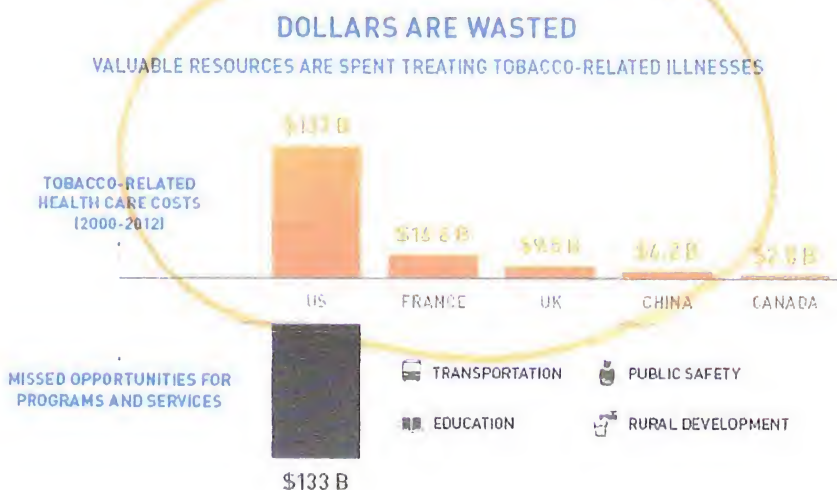
Text Alternative for Tobacco: The True Cost of Smoking

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- Research to Prevent Cancer
- Treatment and Survivorship Research
- ACS Research Updates
- Currently Funded Cancer Research
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- Apply for a Research Grant
- Research Videos
- Cancer Infographics Gallery

American Cancer Society // Infographics // 2015

TOBACCO: THE TRUE COST OF SMOKING

Tobacco use remains the single largest preventable cause of disease and premature death in the US. Yet more than 55.8 million Americans still smoke cigarettes, according to the "National Survey on Drug Use and Health." As of 2013, there were also 12.4 million cigar smokers in the US, 8.8 million smokeless tobacco users (chewing tobacco and snuff), and 2.3 million who smoke tobacco in pipes.



US:
\$133 BILLION
IN HEALTH
RELATED COSTS

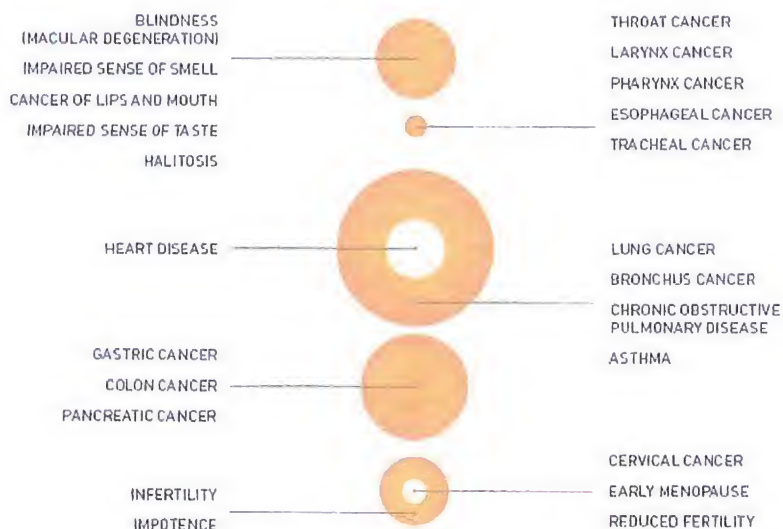
SOCIETY PAYS AND SO DO YOU

THE BURDEN OF DEATH, DISEASE, AND DISABILITY LIES BEYOND THE SMOKER



SMOKING CAUSES DAMAGE THROUGHOUT THE BODY

Tobacco smoke contains more than 7,000 chemicals and compounds. Hundreds of these are toxic, and at least 69 are cancer causing. When you use tobacco, you risk developing:



Cigarette smoking is the **#1** preventable cause of death in the US



1/2 of all those who continue to smoke will die from a smoking-related illness.

DON'T SMOKE AND ENCOURAGE OTHERS NOT TO SMOKE

Quitting tobacco is not easy, but it can be done. Call us at **1-800-277-2345** or visit www.no-tobacco.org to find tips, tools, and resources to help you or someone you love quit for good.

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You Pay, Whether You Smoke or Not

Environmental Impact

Health Impact

Economic Impact

DID YOU KNOW?

Tobacco control programs not only reduce smoking, but also reduce costs! In the past 20 years, California has saved \$86 billion in health care costs due to fewer Californians using tobacco.

We all know how costly smoking is to the smoker. A \$5 pack-a-day habit costs a smoker nearly \$2,000 a year. That's enough for rent for several months or a down payment on a new car! But what about the cost to businesses and our health care system?

Businesses lose money due to smokers missing work more frequently for illness than other workers; they may also pay more for employee health care insurance to cover smokers. In one year, productivity losses in California for early death or illness due to smoking were estimated to be \$8.5 billion.

In 2004, smoking is estimated to have cost California \$9.6 billion in health care expenditures, and of this, the state spent \$2.9 billion on Medicaid/Medi-Cal.

Environmental clean-up costs due to tobacco are also estimated to be significant. According to the California Department of Transportation, cigarette waste is a major contributor to storm drain trash. California public agencies, and ultimately taxpayers, spend over \$41 million annually on litter cleanup, of which cigarette butts account for one-third.

The Problem Impacts of Tobacco Economic Impact

Secondhand Smoke
Tobacco Industry
Impacts of Tobacco

Ads
Videos

'Want to Quit?
Know Someone?

What Can You Do?
Be a Reel Hero
Local Contacts

Past, Present, Future
Program Highlights
Timeline

Additional Sources

CA:
\$9.6 BILLION IN
HEALTH RELATED COSTS



STATE BUDGET SOLUTIONS

REAL Solutions for REAL Budget Problems

RESEARCH

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E-Cigarettes Poised to Save Medicaid Billions

State Budget Solutions | by J. Scott Moody | March 31, 2015

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STATE POLICY ANALYSIS

E-Cigarettes Poised to Save Medicaid Billions

Electronic cigarettes (e-cigs) have only been around since 2006, yet their potential to dramatically reduce the damaging health impacts of traditional cigarettes has garnered significant attention and credibility. Numerous scientific studies show that e-cigs not only reduce the harm from smoking, but can also be a part of the successful path to smoking cessation.

Electronic cigarettes (e-cigs) have only been around since 2006, yet their potential to dramatically reduce the damaging health impacts of traditional cigarettes has garnered significant attention and credibility. Numerous scientific studies show that e-cigs not only reduce the harm from smoking, but can also be a part of the successful path to smoking cessation.

The term "e-cig" is misleading because there is no tobacco in an e-cig, unlike a traditional, combustible cigarette. The e-cig uses a battery-powered vaporizer to deliver nicotine via a propylene-glycol solution-which is why "smoking" an e-cig is called "vaping." The vapor is inhaled like a smoke from a cigarette, but does not contain the carcinogens found in tobacco smoke.

Unlike traditional nicotine replacement therapy (NRT), such as gum or patches, e-cigs mimic the physical routine of smoking a cigarette. As such, e-cigs fulfill both the chemical need for nicotine and physical stimuli of smoking. This powerful combination has led to the increasing demand for e-cigs-8.2% use among nondaily smokers and 6.2% use among daily smokers in 2011.¹

The game-changing potential for dramatic harm reduction by current smokers using e-cigs will flow directly into lower healthcare costs dealing with the morbidity and mortality stemming from smoking combustible cigarettes. These benefits will particularly impact the Medicaid system where the prevalence of cigarette smoking is twice that of the general public (51% versus 21%, respectively).

Based on the findings of a rigorous and comprehensive study on the impact of cigarette smoking on Medicaid spending, the potential savings of e-cig adoption, and the resulting tobacco smoking cessation and harm reduction, could have been up to \$48 billion in Fiscal Year (FY) 2012.² This savings is 87% higher than all state cigarette tax collections and tobacco settlement collections (\$24.4 billion) collected in that same year.

Unfortunately, the tantalizing benefits stemming from e-cigs may not come to fruition if artificial barriers slow their adoption among current smokers. These threats range from the Food and Drug Administration regulating e-cigs as a pharmaceutical to states extending their cigarette tax to e-cigs. To be sure, e-cigs are still a new product and should be closely monitored for long-term health effects. However, given the long-term fiscal challenges facing Medicaid, the prospect of large e-cigs cost savings is worth a non-interventionist approach until hard evidence proves otherwise.

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Table 1

Smokers Represent Significantly Larger Proportion of

Medicaid Recipients than General Population 2011			
State	Percent Smokers		Number of Smokers on Medicaid
	Medicaid	General Population	
United States	51%	21.2% (median)	68,372,045
Alabama	52%	24.3%	938,313
Alaska	66%	22.9%	135,059
Arizona	49%	19.2%	1,989,470
Arkansas	54%	27.0%	777,833
California	45%	13.7%	11,500,583
Colorado	61%	18.3%	733,347
Connecticut	49%	17.1%	729,294
Delaware	58%	21.7%	223,225
Florida	46%	19.3%	3,829,173
Georgia	42%	21.2%	1,925,269
Hawaii	62%	16.8%	313,629
Idaho	62%	17.2%	409,456
Illinois	58%	20.9%	2,900,614
Indiana	68%	25.6%	1,208,207
Iowa	61%	20.4%	544,620
Kansas	54%	22.0%	363,755
Kentucky	65%	29.0%	1,065,840
Louisiana	43%	25.7%	1,293,869
Maine	63%	22.8%	327,524
Maryland	51%	19.1%	1,003,548
Massachusetts	53%	18.2%	1,504,611
Michigan	64%	23.3%	2,265,277
Minnesota	54%	19.1%	989,600
Mississippi	35%	26.0%	775,314
Missouri	66%	25.0%	1,128,505
Montana	70%	22.1%	138,442
Nebraska	64%	20.0%	284,000
Nevada	62%	22.9%	363,357
New Hampshire	80%	19.4%	152,182
New Jersey	36%	16.8%	1,304,257
New Mexico	50%	21.5%	571,621
New York	54%	18.1%	5,421,232
North Carolina	63%	21.8%	1,892,541
North Dakota	63%	21.9%	85,094
Ohio	65%	25.1%	2,526,533
Oklahoma	58%	26.1%	802,603
Oregon	67%	19.7%	690,364
Pennsylvania	70%	22.4%	2,443,909
Rhode Island	48%	20.0%	221,041
South Carolina	41%	23.1%	978,732
South Dakota	69%	23.0%	134,795
Tennessee	58%	23.0%	1,488,267
Texas	43%	19.2%	4,996,318
Utah	54%	11.8%	366,271
Vermont	67%	19.1%	184,088
Virginia	58%	20.9%	1,016,419
Washington	65%	17.5%	1,371,987
West Virginia	67%	25.6%	411,218
Wisconsin	63%	20.9%	1,292,799
Wyoming	62%	23.0%	76,372
District of Columbia	51%	20.8%	235,665

Source: Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, and State Budget Solutions

Prevalence of Smoking in the Medicaid Population

According to the Centers for Disease Control and Prevention, in 2011, 21.2% of Americans smoked combustible cigarettes. However, as shown in Table 1, the smoking rate varies considerably across states with the top three states being Kentucky (29%), West Virginia (28.6%), and Arkansas (27%) and the three lowest states being Utah (11.8%), California (13.7%), and New Jersey (16.8%).³

Additionally, the smoking rate varies dramatically by income level. Nearly 28% of people living below the poverty line smoke while 17% of people living at or above the poverty line smoke.⁴

As a consequence, the level of smoking prevalence among Medicaid recipients is more than twice that of the general public, 51% versus 21%, respectively. However, this too varies considerably across states with the top three states being New Hampshire (80%), Montana (70%), and Pennsylvania (70%) and the three lowest states being Mississippi (35%), New Jersey (36%), and South Carolina (41%).⁵

In absolute terms, the U.S. Medicaid system includes 36 million smokers out of a total Medicaid enrollment of over 68 million. As such, this places much of the health burden and related financial cost of smoking on the Medicaid system which strains the system and takes away scarce resources from the truly needy.

Economic Benefit of Smoking Cessation and Harm Reduction

Smoking creates large negative externalities due to adverse health impacts. Table 2 shows the results of a comprehensive study that quantified the two major costs of smoking in 2009—lost productivity and healthcare costs.⁶

Lost productivity occurs when a person dies prematurely due to smoking or misses time from work due to smoking. This cost the economy \$185 billion in lost output in 2009.

Smokers incur higher healthcare costs when those individuals require medical services such as ambulatory care, hospital care, prescriptions, and neonatal care for conditions caused by smoking. This cost the economy \$116 billion in extra medical treatments.

Overall, in 2009 alone, the negative externalities of smoking cost the U.S. economy \$301 billion in lost productivity and higher healthcare costs. Not surprisingly, these costs were centered in high population states such as California (\$26.9 billion), New York (\$20.6 billion), and Texas (\$20.4 billion).

Literature Review On E-cig Impact On Harm Reduction Through Reduced Toxic Exposure and Smoking Cessation

E-cigs have only been around since 2006, yet their potential to dramatically reduce the damaging health impacts of traditional combustible cigarettes has garnered significant attention and credibility. Numerous scientific studies are showing that e-cigs not only reduce the harm from smoking, but is also a successful path to smoking cessation.

In perhaps the most comprehensive e-cig literature review to date, Neil Benowitz et al. (2014) identified eighty-one studies with original data and evidence from which to judge e-cig effectiveness for harm reduction.⁷ They concluded:

"Allowing EC (electronic cigarettes) to compete with cigarettes in the marketplace might decrease smoking-related morbidity and mortality. Regulating EC as strictly as cigarettes, or even more strictly as some regulators propose, is not warranted on current evidence. Health professionals may consider advising smokers unable or unwilling to quit through other routes to switch to EC as a safer alternative to smoking and a possible pathway to complete cessation of nicotine use."

There are two ways that e-cigs benefit current smokers. First, there is harm reduction for the smoker by removing exposure to the toxicity associated with the thousands of compounds, many carcinogenic, found in the burning of tobacco and the resulting smoke. Second, smoking cessation efforts by the smoker are enhanced by simultaneously fulfilling both the chemical need for nicotine and physical stimuli of smoking.

In the last few years the academic literature has exploded with articles on these two topics. The following is a selection of some of the most recent studies and their conclusions.

Reduced Toxic Exposure

Igor Burstyn (2014) concludes, "Current state of knowledge about chemistry of liquids and aerosols associated with electronic cigarettes indicates that there is no evidence that vaping produces inhalable exposures to contaminants of the aerosol that would warrant health concerns by the standards that are used to ensure safety of workplaces . . . Exposures of bystanders are likely to be orders of magnitude less, and thus pose no apparent concern."⁸

Neal Benowitz, et al. (2013) concludes, "The vapour generated from e-cigarettes contains potentially toxic compounds. However, the levels of potentially toxic compounds in

Table 2
Comprehensive Costs of Smoking
(Billions of Dollars)
2009

State	Lost Productivity			Healthcare Costs	Total Smoking Costs
	Premature Death	Workplace	Total		
United States	117.1	67.5	184.6	116.4	301.0
Alabama	2.7	1.2	3.9	1.7	5.6
Alaska	0.2	0.2	0.4	0.3	0.7
Arizona	1.9	1.3	3.2	1.9	5.1
Arkansas	1.7	0.7	2.4	1.1	3.4
California	9.6	5.7	15.2	11.6	26.9
Colorado	1.3	1.2	2.5	1.6	4.1
Connecticut	1.2	0.7	1.9	1.7	3.6
Delaware	0.4	0.2	0.6	0.4	1.1
District of Columbia	0.3	0.1	0.4	0.5	0.9
Florida	7.9	4.4	12.3	7.3	19.6
Georgia	3.7	2.4	6.2	2.9	9.0
Hawaii	0.4	0.2	0.7	0.4	1.1
Idaho	0.4	0.3	0.7	0.4	1.1
Illinois	5.0	2.9	7.9	4.8	12.7
Indiana	3.0	2.1	5.1	2.6	7.7
Iowa	1.2	0.7	1.9	1.1	3.0
Kansas	1.0	0.6	1.6	1.0	2.6
Kentucky	2.6	1.3	3.9	1.8	5.7
Louisiana	2.4	0.9	3.3	1.8	5.1
Maine	0.6	0.3	0.9	0.7	1.6
Maryland	2.1	1.3	3.4	2.2	5.6
Massachusetts	2.2	1.3	3.4	3.7	7.1
Michigan	4.5	2.4	7.0	4.0	11.0
Minnesota	1.3	1.3	3.0	2.3	5.4
Mississippi	1.8	0.7	2.4	1.0	3.5
Missouri	3.0	1.5	4.5	2.7	7.2
Montana	0.3	0.2	0.6	0.4	0.9
Nebraska	0.6	0.3	1.1	0.7	1.8
Nevada	1.1	0.7	1.7	0.9	2.6
New Hampshire	0.5	0.3	0.8	0.6	1.4
New Jersey	2.9	1.8	4.7	3.6	8.3
New Mexico	0.5	0.4	0.9	0.6	1.5
New York	6.9	3.9	10.8	9.8	20.6
North Carolina	4.1	2.2	6.3	3.4	9.7
North Dakota	0.2	0.2	0.4	0.3	0.7
Ohio	5.7	2.9	8.6	5.2	13.9
Oklahoma	2.1	0.9	3.0	1.3	4.3
Oregon	1.3	0.8	2.1	1.3	3.4
Pennsylvania	5.4	3.2	8.5	5.7	14.2
Rhode Island	0.4	0.2	0.7	0.6	1.3
South Carolina	2.3	1.0	3.3	1.8	4.9
South Dakota	0.3	0.2	0.5	0.3	0.8
Tennessee	3.6	1.7	5.3	2.6	7.9
Texas	7.9	4.9	12.8	7.6	20.4
Utah	0.4	0.3	0.7	0.4	1.1
Vermont	0.2	0.1	0.4	0.3	0.7
Virginia	2.9	2.0	4.8	2.7	7.5
Washington	2.1	1.3	3.4	2.4	5.7
West Virginia	1.1	0.5	1.6	0.9	2.5
Wisconsin	2.0	1.4	3.4	2.4	5.8
Wyoming	0.2	0.2	0.4	0.2	0.6

Source: See Endnote 6 and State Budget Solutions

e-cigarette vapour are 9-450-fold lower than those in the smoke from conventional cigarettes, and in many cases comparable with the trace amounts present in pharmaceutical preparation. Our findings support the idea that substituting tobacco cigarettes with electronic cigarettes may substantially reduce exposure to tobacco-specific toxicants. The use of e-cigarettes as a harm reduction strategy among cigarette smokers who are unable to quit, warrants further study."⁹

Kostantinos E Farsalinos et al. (2014) concludes, "Although acute smoking inhalation caused a delay in LV (Left Ventricular) myocardial relaxation in smokers, electronic cigarette use was found to have no such immediate effects in daily users of the device. This short-term beneficial profile of electronic cigarettes compared to smoking, although not conclusive about its overall health-effects as a tobacco harm reduction product, provides the first evidence about the cardiovascular effects of this device."¹⁰

Smoking Cessation

Emma Beard et al. (2014) concludes, "Among smokers who have attempted to stop without professional support, those who use e-cigarettes are more likely to report continued abstinence than those who used a licensed NRT [Nicotine Replacement Therapy] product bought over-the-counter or no aid to cessation. This difference persists after adjusting for a range of smoker characteristics such as nicotine dependence."¹¹

Christopher Bullen et al. (2013) concludes, "E-cigarettes, with or without nicotine, were modestly effective at helping smokers to quit, with similar achievement of abstinence as with nicotine patches, and few adverse events . . . Furthermore, because they have far greater reach and higher acceptability among smokers than NRT [Nicotine Replacement Therapy], and seem to have no greater risk of adverse effects, e-cigarettes also have potential for improving population health."¹²

Pasquale Caponnetto et al. (2013) concludes, "The results of this study demonstrate that e-cigarettes hold promise in serving as a means for reducing the number of cigarettes smoked, and can lead to enduring tobacco abstinence as has also been shown with the use of FDA-approved smoking cessation medication. In view of the fact that subjects in this study had no immediate intention of quitting, the reported overall abstinence rate of 8.7% at 52-weeks was remarkable."¹³

Konstantinos E. Farsalinos et al. (2013) concludes, "Participants in this study used liquids with high levels of nicotine in order to achieve complete smoking abstinence. They reported few side effects, which were mostly temporary; no subject reported any sustained adverse health implications or needed medical treatment. Several of the side effects may not be attributed to nicotine. In addition, almost every vaper reported significant benefits from switching to the EC [e-cigarette]. These observations are consistent with findings of Internet surveys and are supported by studies showing that nicotine is not cytotoxic, is not classified as a carcinogen, and has minimal effects on the initiation or propagation of atherosclerosis . . . Public health authorities should consider this and other studies that ECs are used as long-term substitutes to smoking by motivated exsmokers and should adjust their regulatory decisions in a way that would not restrict the availability of nicotine-containing liquids for this population."¹⁴

State	Medicaid Spending	Smoking Costs as Percent of Medicaid Spending	Smoking Costs on Medicaid
United States	415,154	11%	45,667
Alabama	5,027	9%	452
Alaska	1,348	15%	202
Arizona	7,905	18%	1,423
Arkansas	4,160	11%	458

Potential E-cig Medicaid Cost Savings

To date, the academic literature strongly suggests that e-cigs hold the promise of dramatic harm reduction for smokers simply by switching from combustible tobacco cigarettes to e-cigs. This harm reduction is due to both its positive impact on smoking cessation and reduced

California	50,165	11%	5,518
Colorado	4,724	17%	503
Connecticut	6,759	7%	473
Delaware	1,485	10%	148
District of Columbia	2,111	11%	232
Florida	17,907	11%	1,970
Georgia	8,526	10%	553
Hawaii	1,493	11%	164
Idaho	1,452	14%	203
Illinois	13,393	11%	1,473
Indiana	7,486	15%	1,123
Iowa	3,495	10%	350
Kansas	2,667	12%	320
Kentucky	5,702	12%	684
Louisiana	7,358	12%	883
Maine	2,413	14%	326
Maryland	7,687	12%	922
Massachusetts	12,926	11%	1,422
Michigan	12,460	13%	1,620
Minnesota	8,894	11%	978
Mississippi	4,466	9%	402
Missouri	8,727	14%	1,222
Montana	973	15%	146
Nebraska	1,722	15%	258
Nevada	1,739	11%	191
New Hampshire	1,187	15%	178
New Jersey	10,389	6%	623
New Mexico	3,430	12%	412
New York	53,306	11%	5,864
North Carolina	12,282	11%	1,381
North Dakota	744	12%	89
Ohio	16,352	13%	2,126
Oklahoma	4,642	12%	557
Oregon	4,587	15%	688
Pennsylvania	20,393	11%	2,243
Rhode Island	1,656	8%	148
South Carolina	4,848	11%	533
South Dakota	749	16%	120
Tennessee	8,798	11%	968
Texas	28,286	11%	3,111
Utah	1,903	14%	266
Vermont	1,353	15%	203
Virginia	6,906	11%	760
Washington	7,560	18%	1,361
West Virginia	2,790	11%	307
Wisconsin	7,096	13%	923
Wyoming	528	16%	85
Note: States do not sum to Total due to rounding.			
Source: See Endnote 15 and State Budget Solutions			

exposure to toxic compounds in cigarette smoke.

As a result, we can expect the healthcare costs of smoking to decline over time as the adoption of e-cigs by smokers continues to grow. Additionally, we can expect greater rates of adoption as e-cigs continue to evolve and improve based on market feedback—a dynamic that has never existed with other nicotine replacement therapies.

As discussed earlier, the potential savings to the economy are very large. In terms of healthcare alone, most of that cost is currently borne by the Medicaid system where the prevalence of cigarette smoking is twice that of the general public, 51% versus 21%, respectively. So what are the potential healthcare savings to Medicaid?

Brian S. Armour et al. (2009) created an impressive economic model to estimate how much smoking costs Medicaid based on data from the Medical Expenditure Panel Survey and the Behavioral Risk Factor Surveillance System.¹⁵

Overall, their model "... included 16,201 adults with weighting variables that allowed us to generate state representative estimates of the adult, noninstitutionalized Medicaid population."

The study concluded that 11% of all Medicaid expenditures can be attributed to smoking. Additionally, among the states

these costs ranged from a high of 18% (Arizona and Washington) to a low of 6% (New Jersey).

This study uses their percentage of Medicaid spending due to smoking and applies it to the latest year of available state-by-state Medicaid spending. As shown in Table 3, in FY 2012, smoking cost the Medicaid system \$45.7 billion. Of course, the largest states bear the brunt of these costs such as New York (\$5.9 billion), California (\$5.5 billion), and Texas (\$3.1 billion).

To put this potential savings to Medicaid into perspective, in FY 2012, state governments and the District of Columbia combined collected \$24.4 billion in cigarette excise taxes and tobacco settlement payments. As shown in Table 4, the potential Medicaid savings exceeds cigarette excise tax collections and tobacco settlement payments by 87%.

However, this varies greatly by state with high ratios in the South Carolina (435%), Missouri (409%), and New Mexico (260%), Arizona (238%), and California (238%) and low ratios in New Jersey (-39%), New Hampshire (-31%), Rhode Island (-17%), Connecticut (-13%), and Hawaii (-4%). Overall, 45 states and D.C. stand to gain more from potential Medicaid savings than through lost cigarette tax collections and tobacco settlement payments.

Note that many of the five states with negative ratios are distorted because excise tax collections are based on where the initial sale occurred and not where the cigarettes were ultimately consumed. This can vary greatly because of cigarette smuggling and cross-border shopping created by state-level differentials in cigarette excise taxes.¹⁶

For instance, New Hampshire has long been a source for out-of-state cigarette purchase from shoppers living in Massachusetts, Maine, and Vermont because of its lower cigarette excise tax. As such, the ratio is too high for Massachusetts, Maine, and Vermont and too low for New Hampshire. The same applies to New Jersey and Connecticut vis-à-vis New York and, more specifically, New York City, which levies its own cigarette tax on top of the state tax.

Hawaii is an exception due to its physical isolation which creates monopoly rents. Rhode Island levies a very high cigarette excise tax, but not relatively high enough compared to neighboring Connecticut and Massachusetts to drive a lot of cross-border shopping.

Other Potential E-cig Cost Savings

Another area of cost savings from greater e-cig adoption is the reduction in smoke and fire dangers in subsidized and public housing. According to a recent study, smoking imposes three major costs:

1. Increased healthcare costs from exposure to second hand smoke within and between housing units.
2. Increased renovation costs of smoking-permitted housing units.
3. Fires attributed to cigarettes.

As shown in Table 5, the study estimates that smoking imposes a nationwide cost of nearly \$500 million.¹⁷ The top three states facing the greatest expenses are New York (\$125 million), California (\$72 million), and Texas (\$24 million) while the top three states with the lowest expenses are Wyoming (\$0.6 million), Idaho (\$0.8 million), and Montana (\$1 million).

State	Smoking Costs
United States	496.8
New York	124.7
California	72.4
Texas	25.3
Massachusetts	24.0
Florida	23.2
Ohio	21.7
Pennsylvania	17.7
New Jersey	15.8
Idaho	11.1

Applying Cigarette Taxes to E-cigs?

Many policymakers around the country have suggested applying the existing cigarette tax, wholly or in part, to e-cigs. This is bad public policy and is based on a

State	State Cigarette Tax Collections (a)	Tobacco Settlement Payments (b)	Smoking Costs on Medicaid	Smoking Costs on Medicaid as a Percent of State Cigarette Tax Collections and Tobacco Settlement Payments
United States	17,226	7,190	45,667	87%
Alabama	126	94	452	106%
Alaska	67	30	202	108%
Arizona	319	101	1,423	235%
Arkansas	247	51	458	54%
California	896	736	5,518	235%
Colorado	203	91	803	173%
Connecticut	418	124	473	-13%
Delaware	121	27	148	1%
District of Columbia	36	38	232	214%
Florida	361	365	1,970	164%
Georgia	227	141	853	132%
Hawaii	122	49	164	-4%
Idaho	48	25	203	177%
Illinois	606	274	1,473	67%
Indiana	465	130	1,123	89%
Iowa	225	66	350	20%
Kansas	104	56	320	98%
Kentucky	277	102	684	81%
Louisiana	133	141	883	222%
Maine	140	51	338	77%
Maryland	411	146	922	66%
Massachusetts	574	254	1,422	72%
Michigan	965	256	1,620	33%
Minnesota	422	167	978	66%
Mississippi	157	110	402	50%
Missouri	105	135	1,222	409%
Montana	87	30	146	24%
Nebraska	68	38	258	145%
Nevada	103	40	191	34%
New Hampshire	215	43	178	-31%
New Jersey	792	231	623	-39%
New Mexico	75	39	412	260%
New York	1,632	738	5,864	147%
North Carolina	295	141	1,351	210%
North Dakota	28	32	89	49%
Ohio	843	295	2,128	87%
Oklahoma	293	77	557	50%
Oregon	256	79	685	106%
Pennsylvania	1,119	337	2,243	54%
Rhode Island	132	47	148	-17%
South Carolina	26	73	533	435%
South Dakota	60	24	120	42%
Tennessee	279	139	968	131%
Texas	1,470	475	3,111	60%
Utah	124	36	266	68%
Vermont	80	35	203	77%
Virginia	192	117	760	145%
Washington	471	151	1,361	119%
West Virginia	110	64	307	77%
Wisconsin	653	131	923	18%
Wyoming	26	19	85	90%

(a) Includes all forms of tobacco taxes.

(b) Includes Master Settlement Agreement and individual state payments.

Source: Department of Commerce, Census Bureau, Internal Revenue Service, and

State	Percentage
North Carolina	13.9
Illinois	13.3
Tennessee	12.9
Michigan	12.8
Alabama	12.4
Georgia	11.6
Connecticut	10.7
Missouri	9.4
Indiana	8.3
Virginia	7.8
Mississippi	7.2
Kentucky	7.1
Minnesota	7.1
South Carolina	7.0
Maryland	7.0
Arkansas	6.8
Oklahoma	6.8
Wisconsin	6.5
Washington	5.0
Arizona	4.9
Colorado	4.5
West Virginia	4.3
Oregon	4.3
Maine	4.2
Rhode Island	4.0
Hawaii	3.8
Iowa	3.8
New Mexico	3.0
Kansas	2.9
Nebraska	2.1
Nevada	1.9
Vermont	1.9
New Hampshire	1.9
Utah	1.4
Delaware	1.3
North Dakota	1.2
South Dakota	1.1
Montana	1.0
Idaho	0.8
Wyoming	0.6
Alaska	N.A.
District of Columbia	N.A.
Source: See Endnote 17 and State Budget Solutions	

fundamental

State Budget Solutions

misunderstanding of the cigarette tax.

The cigarette tax is what economists call a "Pigovian Tax" which is designed to mitigate negative externalities of certain actions. Cigarette smoking creates many negative externalities such as harmful health consequences to the user or to those in near proximity (second-hand smoke).

As detailed in this study, the negative externalities associated with traditional smoking are all but eliminated by e-cigs. Without evidence of actual negative externalities, applying the existing cigarette tax to e-cigs is simply bad public policy.

Conclusion

Policymakers have long sought to reduce the economic damage due to the negative health impact of smoking. They have used tactics ranging from cigarette excise taxes to subsidizing nicotine replacement therapies. To be sure, smoking prevalence has fallen over time, but there is more that can be done, especially given the fact that so much of the healthcare burden of smoking falls on the already strained Medicaid system.

As with any innovation, no one could have predicted the sudden arrival into the marketplace of the e-cig in 2006. Since e-cigs fulfill both the chemical need for nicotine and physical stimuli of smoking the demand for e-cigs has grown dramatically. The promise of a relatively safe way to smoke has the potential to yield enormous healthcare savings. The most current academic research verifies the harm reduction potential of e-cigs.

As shown in this study, the potential savings to Medicaid significantly exceeds the state revenue raised from the cigarette excise tax and tobacco settlement payments by 87%. As such, the rational policy decision is to adopt a non-interventionist stance toward the evolution and adoption of the e-cig until hard evidence proves otherwise. While cigarette tax collections will fall as a result, Medicaid spending will fall even faster. This is a win-win for policymakers and taxpayers.

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